

<b>Case Number:</b>	CM15-0194607		
<b>Date Assigned:</b>	10/09/2015	<b>Date of Injury:</b>	10/07/2014
<b>Decision Date:</b>	11/12/2015	<b>UR Denial Date:</b>	10/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Anesthesiology

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 46 year old male, who sustained an industrial injury on 10/7/2014. The injured worker is undergoing treatment for: thoracic spine disc herniation, thoracic spine sprain and strain, cervical spine sprain and strain, possible lumbar radiculopathy. On 4-3-15, a QME report documented "he should have access to additional chiropractic treatment" and indicated the injured worker to have paid for chiropractic treatment on his own and reported it as helpful. On 9-9-15, he reported having "no change in his symptoms". He reported having continued constant upper and mid back pain that is worsened with activities such as cooking and bending. He indicated there is occasional pain radiation into the left calf. Objective findings revealed tenderness to trapezius bilaterally, restricted range of motion of the neck and low back, his gait is noted to be normal, and there is normal lumbar lordosis and thoracic kyphosis documented. The records indicate there was previous chiropractic treatment; however, there is no discussion of the results or discussion of how the injured worker found the treatment to be helpful. There is no discussion of the efficacy of Celebrex. The treatment and diagnostic testing to date has included: magnetic resonance imaging of the lumbar spine (6-8-15), magnetic resonance imaging of the thoracic spine (11-14-14), QME (4-3-15), at least 9 sessions of physical therapy with a notation of no improvement documented in the medical records for dos 11-7-14, radiograph cervical and thoracic spines (7-27-15), home exercise program. Medications have included: carvedilol, Lisinopril, Celebrex. Celebrex has been utilized since at least April 2015, possibly longer. Current work status: documented as restricted. The request for authorization is for: chiropractic treatments 2 times a week for 6 weeks for the cervical spine, thoracic spine and

lumbar spine, total visits 12; repeat magnetic resonance imaging of the lumbar spine without contrast; 12 acupuncture visits for cervical spine, thoracic spine and lumbar spine; Celebrex 200mg by mouth daily. The UR dated 10-1-2015: modified certification of 6 chiropractic treatments for the cervical spine, thoracic spine and lumbar spine, total visits 6; non-certified the repeat magnetic resonance imaging of the lumbar spine without contrast; non-certified 12 acupuncture visits for cervical spine, thoracic spine and lumbar spine; and non-certified Celebrex 200mg by mouth daily.

### **IMR ISSUES, DECISIONS AND RATIONALES**

The Final Determination was based on decisions for the disputed items/services set forth below:

**Repeat MRI of lumbar spine without contrast: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, MRI's.

**Decision rationale:** According to California MTUS Guidelines, MRI of the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is no indication for a repeat MRI of the lumbar spine. The documentation indicates that the claimant had an MRI of the lumbar spine on 06/08/2015. There are no subjective complaints of increased back pain, radiculopathy, bowel or bladder incontinence, and there are no new neurologic findings on physical exam. Therefore, there is no specific indication for a repeat MRI of the lumbar spine. Medical necessity for the requested MRI of the lumbar spine without contrast has not been established. The requested imaging is not medically necessary.

**12 acupuncture visits, cervical, thoracic & lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**Decision rationale:** The California MTUS Acupuncture guidelines apply to all acupuncture requests, for all body parts and for all acute or chronic, painful conditions. According to the Acupuncture Medical Treatment Guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten recovery. The treatment guidelines support acupuncture treatment to begin as an initial treatment of 3-6 sessions over no more than two weeks. If functional improvement is documented, as defined by the guidelines further treatment will be considered. In this case, the initial request (of 12 visits) exceeds the guideline recommendations. Medical necessity for the requested cervical, thoracic, and lumbar spine acupuncture visits has not been established. The requested services are not medically necessary.

**Chiropractic treatment, 2 times a week for 6 week, cervical spine, thoracic spine & lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** According to the CA MTUS/ACOEM guidelines, Manual Therapy or Chiropractic manipulation is a treatment option during the acute phase of injury, and manipulation should not be continued for more than a month, particularly when there is not a good response to treatment. The MTUS states that is recommended for chronic pain if it is caused by musculoskeletal conditions. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The ODG states that cervical manipulation may be a treatment option for patients with occupationally related neck pain or cervicogenic headache. The ODG recommends up to 18 total chiropractic and massage visits over 6-8 weeks for cervical and thoracic injuries with evidence of functional improvement after a 6 visit initial trial. For the treatment of low back pain, a trial of 6 visits is recommended over 2 weeks, with evidence of objective improvement, with a total of up to 18 visits over 6-8 weeks. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. In addition, there are associated requests for acupuncture without a clear documentation of a rationale for providing concurrent physical modalities. In this case, the requested number of sessions exceeded the MTUS recommendation. Medical necessity for the requested Chiropractic treatment, 2 times a week for 6 week, of the cervical spine, thoracic spine & lumbar spine, has not been established. The requested services are not medically necessary.

**Celebrex 200mg p.o daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

**Decision rationale:** Celebrex (Celecoxib) is a nonsteroidal anti-inflammatory drug (NSAID) that is a COX-2 selective inhibitor, a drug that directly targets COX-2, an enzyme responsible for inflammation and pain. Unlike other NSAIDs, Celebrex does not appear to interfere with the antiplatelet activity of aspirin and is bleeding neutral when patients are being considered for surgical intervention or interventional pain procedures. Celebrex may be considered if the patient has a risk of GI complications, but not for the majority of patients. Generic NSAIDs and COX-2 inhibitors have similar efficacy and risks when used for less than 3 months. In this case, there is no documentation of GI side effects from generic NSAIDs to support the use of Celebrex. The medical necessity of the requested medication has not been established. The requested medication is not medically necessary.